CAQH CORE

Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule v.5.0.0

Phase V CAQH CORE Operating Rule Set: Executive Summary

The Phase V CAQH CORE Prior Authorization Operating Rules focus on standardizing components of the prior authorization process, closing gaps in electronic data exchange to move the industry toward a more automated adjudication of a request. The Phase V Operating Rules build on prior phases of CAQH CORE Operating Rules, including the Phase IV CAQH CORE 452 Health Care Services Review – Request for Review and Response (278) Infrastructure Rule. To develop the two Phase V Operating Rules, CAQH CORE conducted an environmental scan of over 100 entities, participated in industry meetings and convened multi-stakeholder groups to agree on opportunities for operating rule development and refine draft requirements.

The Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule requirements target one of the most significant problem areas in the prior authorization process: requests for medical services that are pended due to missing or incomplete information, primarily medical necessity information. The rule applies when any HIPAA-covered entity and its agent uses, conducts or processes the X12/005010X217 Health Care Services Review – Request for Review and Response (278) transactions. Rule requirement areas, which pertain to prior authorization for procedures, laboratory testing, medical services, devices, supplies or medications within the medical benefit include:

- Consistent submission of patient identifying information and subsequent normalization of patient last name to reduce common errors and associated denials.
- Return of the most specific AAA Error and Action Codes in the Response when certain errors are detected in the request.
- Return of one or more Health Care Service Decision Reason Codes (HCSDRC) in the Health Care Services (HCR) Segment to provide the clearest explanation to the submitter.
- When a request is pended for additional documentation, use the PWK01 Attachment Report Type Code, or use of appropriate Logical Observation Identifier Names and Codes (LOINC) and PWK01 Attachment Report Type Code, and return the HCR01 Action Code of A4 Pended to provide clearer direction on status and what additional information is needed for adjudication.
- Detection and display of code descriptions to reduce burden of interpretation.

The Phase V CAQH CORE Prior Authorization Web Portal Rule builds a bridge toward overall consistency for referral and prior authorization requests and responses by addressing fundamental uniformity for data field labels, ensuring confirmation of the receipt of a request providing for system availability. The rule applies when any entity and its agent make available a web portal to a provider to submit a referral or prior authorization request for any healthcare service and corresponding response. Rule requirement areas pertaining to referral and prior authorization for procedures, laboratory testing, medical services, devices, supplies or medications within the medical benefit include:

- Use of the 5010X217 278 Request and Response TR3 Implementation Names or Alias Names for the web portal data field labels.
- System availability requirements for a health plan to receive a referral or prior authorization request to enable predictability for providers.
- Confirmation of receipt of a referral or prior authorization request web form submission to reduce manual follow-up for providers.

Adherence to the requirements outlined in the Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule when the portal operator maps the collected data from the web portal to the 5010X217 278 Request and Response transaction.

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1. Phase V CAQH CORE Operating Rule Set: Background[1]

1.1. CAQH CORE Overview

CAQH CORE is an industry-wide facilitator committed to the creation and adoption of healthcare operating rules that support standards, accelerate interoperability and align administrative and clinical activities among providers, health plans and patients. Guided by over 130 participating organizations – including providers, health plans, government entities, vendors, associations and standards development organizations – CAQH CORE Operating Rules drive a trusted, simple and sustainable healthcare information exchange that evolves and aligns with market needs.[2] To date, this cross-industry commitment has resulted in four phases of operating rules addressing many pain points of healthcare business transactions, including: eligibility and benefits verification, claims and claims status, claim payment and remittance, health plan premium payment, enrollment and disenrollment and prior authorization.

1.2. Industry Interest in Prior Authorization Operating Rules

Prior authorization is currently a time-consuming and costly process, and a critical area of industry interest as all parties stand to benefit from greater efficiency. A recent American Medical Association study revealed that a majority of surveyed providers report increased burden associated with prior authorization over the past five years. On average, these physician practices complete 31 prior authorizations per physician per week resulting in 36 percent of practices hiring staff to work exclusively on prior authorizations.[3] By developing consensus statements, attending conferences and working through associations and work groups, industry stakeholders are actively developing improvements to reduce administrative burden, improve continuity of care and enhance overall patient experience and outcomes. CAQH CORE works extensively alongside these complementary efforts to develop pathways to automate parts of the prior authorization process with CAQH CORE Operating Rules.

CAQH CORE addressed some components of the prior authorization process in its Phase IV Operating Rules. The Phase IV CAQH CORE 452 Health Care Services Review – Request for Review and Response (278) Infrastructure Rule applies to the X12/005010X217 Health Care Services Review – Request for Review and Response (278)[4] transactions (hereafter referred to as "5010X217 278 Request and Response").The CAQH CORE Phase IV rule established foundational requirements that build consistency with other operating rules for HIPAA transactions, including receipt acknowledgement, common connectivity methods (i.e., a "safe harbor"), required response times, minimum system availability and a common companion guide format.

The proven CAQH CORE model for working with industry consists of continuous feedback channels to research and develop rules, measure adoption, enhance existing rules and create new rules. Industry feedback, as well as federal recommendations, demonstrate significant interest in additional operating rules to further streamline the prior authorization process. The National Committee on Vital and Health Statistics (NCVHS), a public advisory committee to the Secretary of the Department of Health and Human Services (HHS), recommended additional research to understand barriers to improving the prior authorization process and additional operating rules to address these barriers.[5] Specifically, NCVHS

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[1] Section 1 (Background) and Section 2 (Issue to Be Addressed and Business Requirement Justification) of the Phase V CAQH CORE Operating Rules are identical in the Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule and the Phase V CAQH CORE Prior Authorization Web Portal Rule.

[2] In 2012, CAQH CORE was designated by the Secretary of the Department of Health and Human Services (HHS) as the author for federally mandated operating rules under Section 1104 of the Patient Protection and Affordable Care Act (ACA). See Appendix Section 5.1 for more information.

[3] 2018 AMA Prior Authorization Physician Survey, American Medical Association.

[4] The X12 Technical Report Type 3 that details the full requirements for this transaction along with the license for its use is available at http://store.x12.org/store/. Note: Permission to use X12 copyrighted materials within this document has been granted.

[5] Letter to the Secretary - Recommendations for the Proposed Phase IV Operating Rules, National Committee on Vital and Health Statistics.

recommended that, given the relatively low adoption of the 5010X217 278 Request and Response, requirements be considered to further enhance its "usefulness and effectiveness" and that research be conducted to identify "why portals and other HIPAA-compliant alternative technology data exchange means are more effective and provide all the necessary and useful information, compared to the adopted transaction standard."[6] NCVHS also recommended that operating rules contain data content requirements to further explain "pended" statuses and "encourage payers and providers to standardize across all systems to ensure consistency in transmitting and receiving information…including payer portals."[7,8]

CAQH CORE participant and industry-wide surveys have shown growing industry commitment to the development of the data content operating rules for the 5010X217 278 Request and Response. In 2012 and 2013, surveys prioritized infrastructure requirements as a foundational step for the Phase IV transactions. Results also revealed that, relative to the other transactions surveyed[9], interest in data content requirements was highest for prior authorization. In 2017, CAQH CORE participating organizations ranked prior authorization operating rule opportunities, including those related to data content, workflow, format, transport and utilities.[10] Data content and workflow received the highest percentage of support and the highest priority rankings. With continued industry interest and commitment to driving greater efficiency regarding prior authorization, CAQH CORE will continue to engage the industry on additional operating rules related to prior authorization in the near future.

2. Phase V CAQH CORE Operating Rule Set: Issues to Be Addressed and Business Requirement Justification

2.1. Problem Space

Prior authorization began as a means to manage the utilization of healthcare resources: people, time and dollars. It requires providers to request approval from a health plan before a specific procedure, laboratory test, service, device, supply or medication is provided to the patient. Referrals require a provider to obtain approval from a health plan before a patient can be referred to another provider (e.g., specialist).

Each step of the prior authorization process is labor-intensive and generates time-consuming and costly administrative burden for provider organizations as well as health plans and can delay patient care. These inefficiencies can largely be attributed to a lack of uniformity in prior authorization processes across and within health plans. Lack of uniformity perpetuates a need for manual intervention (i.e., phone, fax, human involvement) to proceed to the next step. While electronic methods (5010X217 278 Request and Response, web portal, etc.) reduce manual intervention in certain parts of the prior authorization process, the end-to-end workflow still requires manual intervention in almost all components of the process, from gathering and submitting provider information to adjudication of the request by the health plan. Further, the prior authorization process is siloed; it is separate from the patient eligibility and claims processes. These siloes can impact the delivery of patient care, provider reimbursement and can result in

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[6] Letter to the Secretary - Findings from Administrative Simplification Hearing, National Committee on Vital and Health Statistics.

[7] Letter to the Secretary - Recommendations for the Proposed Phase IV Operating Rules, National Committee on Vital and Health Statistics.

[8] Review Committee Findings and Recommendations on Adopted Standards and Operating Rules, National Committee on Vital and Health Statistics.

[9] X12/005010X222 Health Care Claim (837) Professional, X12/005010X223 Health Care Claim (837) Institutional, and X12/005010X224 Health Care Claim (837) Dental; X12/005010X220 Benefit and Enrollment Maintenance (834); X12/005010X218 Payroll Deducted and Other Group Premium Payment for Insurance Products (820); Claim Attachments.

[10] Descriptions of categories: Data Content: Includes opportunities for the data content of electronic transactions; Work Flows: Addresses business processes for prior authorization and/or eligibility; Formats: Describes the type of document format in which prior authorization data is collected and delivered to the health plans by providers; Transport: Addresses the method by which prior authorization data is delivered to the health plans by providers; Utilities: Includes industry-wide solutions such as a prior authorization-specific clearinghouse.

unintended patient out-of-pocket expenses. Approval for a requested prior authorization does not guarantee that the claim subsequently submitted will be approved for reimbursement.

CAQH CORE conducted extensive research to understand the barriers to automation of the prior authorization and referral process. Research revealed that each part of the process varies in its maturity level, falling along a spectrum of automation, from manual to automated. It also revealed that while referrals are still often done manually, they are not nearly as burdensome as obtaining a prior authorization. The research engaged over 100 entities via participation in surveys, interviews and site visits. An industry Advisory Group led by CAQH CORE, with provider, health plan, vendor and government representation, guided the research and analysis of results, as well as subsequent prioritization of opportunities to address the identified issues.

2.1.1. Barriers to Automation of the Prior Authorization Process

The prior authorization process begins when a provider determines that a patient needs a medical service, special medical equipment or medications[11] and related supplies. To understand if a prior authorization is required for provision of that service, provider staff often manually review lists of services requiring prior authorization. These lists differ by and within health plans. There is also a lack of uniformity in data field requirements for the requests themselves, which leads provider staff to seek clarification by phone. Provider-facing web portals also offer access to the lists of services requiring prior authorization. While these lists may be more frequently updated than lists available via other look-up methods, outdated information is still an issue, given how frequently the requirements can change. Once a provider confirms that a prior authorization request is required, portals may also allow the provider to look up the requirements for that specific request and submit the request from a single web-based application. The functionality of portal-based lists varies in sophistication. Some health plans use a more manual PDF look-up process, while others employ a search capability to find the prior authorization requirements by procedure code.

The retrieval of information required to accompany a prior authorization request is also mostly manual. Demonstrating medical necessity for a service requires access to systems that house clinical data. Due to the relative lack of integration between clinical and administrative systems, providers often rely on non-electronic methods of data retrieval, including phone and fax. Some providers may have a solution in place that provides integration between systems and allows for time savings from reduction in manual keystrokes.

Prior authorization request submission options range from manual (phone, fax, email) to electronic (5010X217 278 Request and Response, web portal and interactive voice response). According to the 2018 CAQH Index, 51 percent of prior authorization requests are submitted manually, 36 percent are submitted via web portal or interactive voice response and 12 percent are submitted via the 5010X217 278 Request.[12] While manual options, such as the phone, may seem more burdensome, providers report that this method frequently results in the most clarity regarding requirements, status and next steps. In addition, both health plans and providers indicate that competing electronic options do not yet offer enough benefit.

Provider-facing web portals are one of the most common methods for prior authorization submission— they offer more automation than phone— and many portal-based requests are mapped to the 5010X217 278 Request and Response for processing. However, the lack of data field uniformity and consistency consumes a significant amount of provider staff time. For each health plan, with which the provider contracts, provider staff must log into a different portal to key information into the system manually. As a result, providers need to employ and train personnel in the specifics of each web portal, resulting in considerable time to enter the data for one patient.

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[11] Pharmacy benefit electronic prior authorization is out-of-scope for this rule set, i.e., pharmacist- or prescriber-initiated prior authorizations for drugs/biologics/other treatments covered under a pharmacy benefit are not a function of the web portals addressed in this rule as drug authorizations covered under the pharmacy benefit are the function of the National Council for Prescription Drug Programs (NCPDP).
[12] 2018 CAQH Index, CAQH.

The standard transaction 5010X217 278 Request and Response is the federally mandated standard for prior authorization under HIPAA; however, it is not a viable option if the provider does not have the system to support it. This is common given that vendor solutions do not always support the 5010X217 278 Request and Response transaction, partially due to low adoption and business needs that occur outside of the 5010X217 278 Request and Response (e.g., provision of additional documentation or attachments that do not yet have a federally mandated standard). When vendors do offer the 5010X217 278 Request and Response, the transaction is typically offered only in a premium configuration that providers may not choose to purchase due to cost and relative lack of benefit given the low user base. In general, even when providers are ready to submit a prior authorization request, the availability of a system to receive the request is not always consistent, and it is difficult to determine such availability. Finally, once a provider submits the request, there may be no indication that the submission was successfully received.

Once the health plan receives a prior authorization request, most are routed through a manual internal review rather than an automated adjudication process. This especially pertains to requests that require additional medical documentation. Some health plans are able to automate the adjudication process when no additional documentation is needed. Health plans are regularly limited by a lack of robust electronic communication channels and are unable to update the provider in a timely fashion, to communicate errors, to indicate the need for additional information and to identify next steps. Providers routinely call the health plan to determine the status of the request, as well as any next steps to get the request approved. Missing or incomplete information, including proof of medical necessity, is one of the most common reasons for a health plan to pend a request. Providers are not always able to include this information on the request itself, either because it is not known or they need to transmit it separately from the prior authorization request. Missing or incomplete information, as well as code errors, lengthen the time to final adjudication and further delay patient care. Ultimately, when the health plan has collected the information it needs to render a decision, the health plan delivers the decision back to the provider. This decision is usually communicated to the provider via a decision notice letter, a returned provider review letter, a web portal notification or over the phone, which is often the quickest method for individual providers to retrieve the final determination response from health plans.

Many points along the prior authorization process fall to manual steps for both providers and health plans, often due to lack of application systems and software developed to enable automation. As stated above, providers drop to manual or partially manual processes from the initiation of the request to the final status of the prior authorization – using phone, fax and web portal tools. Health plans are equally challenged with supporting the entire process through a fully developed auto-adjudication system or platform. This is often due to the complexity of the prior authorization process, as well as the various systems and databases that need to be accessed along with many competing priorities.

According to the 2018 CAQH Index[13], full adoption of the standard prior authorization transaction (5010X217 278 Request and Response) by health plans and providers could result in a savings of $7.28 per transaction, for the portions of the prior authorization process included in the 5010X217 278 Request and Response. However, the proportion of prior authorization transactions using the standard remains much lower, relative to the other standard transactions, and progress to reduce the use of costly, time-consuming manual transactions has waned.[14] There is significant opportunity to strengthen existing electronic tools for prior authorization and move toward a more automated process.

2.2. CAQH CORE Process in Addressing the Problem Space

Once the barriers to automation were clearly defined, CAQH CORE developed a list of opportunity areas for potential industry resolution that would address pain points and increase industry adoption of electronic prior authorization. These opportunity areas were cultivated via a thorough review and analysis of the X12/005010X217 Health Care Services Review – Request for Review and Response (278) Technical Report Type 3, public comment and testimonies submitted to NCVHS, industry forum discussions and initiatives, CAQH CORE industry surveys and Phase IV CAQH CORE Subgroup

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[13] Ibid.
[14] CAQH CORE Board Prior Authorization Response Letter, CAQH.

discussions. During this stage, CAQH CORE identified over 20 unique opportunity areas for improving the prior authorization process.

A CAQH CORE Prior Authorization Advisory Group with a diverse mix of provider, health plan, vendor and government representation used agreed-upon evaluation criteria (e.g. benefits across stakeholder types, effective approach, etc.) to prioritize which opportunity areas should be addressed via operating rules. Opportunity areas that were discussed but ultimately did not rise to the top for development in this rule set (but could be addressed in the future) pertain to a list of services for which prior authorization is required/not required (including not required for emergency services[15]), as well as a timeframe for sending a final determination. Opportunities that rose to the top related to data content, standardizing the prior authorization request and response for all formats (e.g. web portals), workflows and attachments (additional documentation). The Advisory Group sent these to the Subgroup for further specification.

The Advisory Group charged a CAQH CORE Prior Authorization Subgroup with creating operating rules for data content requirements for the 5010X217 278 transaction and the standardization of prior authorization requests and responses. Given pending federal regulations regarding standards for attachments (additional documentation), operating rules for attachments were put on hold. CAQH CORE has since launched a separate initiative related to attachments (additional documentation), and operating rules may be expected in a subsequent phase of rule writing. Furthermore, given the current varied and proprietary nature of workflows, the Advisory Group advised that more assessment and research were needed. As a result, the opportunity area will be considered for future CAQH CORE operating rules.

To develop operating rules for the chosen opportunity areas, the CAQH CORE Prior Authorization Subgroup responded to a series of surveys and participated in discussions to further identify potential requirements within these opportunities. Subgroup participants were asked to identify the most common reasons for prior authorization denials and pended responses. From there, potential rule options were drafted. Subgroup participants then completed straw polls to indicate their support for each rule option and build out rule requirements.

2.3. *Focus of the Phase V CAQH CORE Operating Rules*

The following rule options addressing data content of the electronic prior authorization transaction or web portals received the highest support from the CAQH CORE Prior Authorization Subgroup:

- Consistent **patient identification and verification** on prior authorization requests.
- Additional guidance on situational use of **AAA Error Codes and corresponding action codes.**
- Receipt and processing of **diagnosis/procedure/revenue codes** for specified categories of services on the Request to enable adjudication.
- Use of **LOINC and PWK01 Attachment Report Type Codes** to communicate what additional clinical documentation is needed from the provider to move a pended prior authorization request forward.
- Use of **HCSDRCs** to provide the most comprehensive information back to the provider.
- Application of **standard X12 data field labels** to web portals to reduce variation and ease submission burden.
- **Confirmation of receipt of prior authorization or referral request** (submitted via web portal) to reduce manual follow-up for providers.
- **System availability requirements** for a health plan to receive a prior authorization or referral request, to enable predictability for providers when using a web portal.

The Phase V CAQH CORE Operating Rules, including the Prior Authorization (278) Request / Response Data Content Rule and the Prior Authorization Web Portal Rule, represent the next step toward a less manual, more uniform and consistent prior authorization process. This phase of rules focuses on standardizing components of the prior authorization process by closing gaps in electronic data exchange to move the industry toward a fully automated prior authorization adjudication process, similar to the

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[15] The ACA prohibits requirements for prior authorization to access emergency services under section 29 CFR 2590.715-2719A, patient protections. In line with federal law, a growing number of state laws set additional limits around prior authorizations for emergency and urgent care.

success the industry has seen in the claims adjudication model. The Phase V CAQH CORE Operating Rules allow the industry to focus its resources on areas of the prior authorization process that can most benefit from automation and development of systems and applications. These efforts build momentum to a fully automated adjudication of a prior authorization.

2.3.1. Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule

The Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule[16,17] requirements target one of the most significant problem areas in the prior authorization process: requests for medical services that are pended due to missing or incomplete information, primarily medical necessity information. These enhancements reduce the unnecessary back and forth between providers and health plans and enable shorter adjudication timeframes and reduced staff resources spent on manual follow-up. The rule – which applies to prior authorizations for procedures, laboratory testing, medical services, devices, supplies or medications within the medical benefit – reduces barriers to adoption by:

- Strengthening the data submitted by the provider on the prior authorization request and the communication of next steps by the health plan on the response.
- Easing the burden of interpretation on the provider by standardizing code use and requiring display of code descriptions.
- Allowing for more efficient review and adjudication of prior authorization requests, by focusing on aspects of the process that can most benefit from systems and application development.

2.3.2. Phase V CAQH CORE Prior Authorization Web Portal Rule

The Phase V CAQH CORE Prior Authorization Web Portal Rule[18] builds a bridge toward overall consistency for referral and prior authorization requests and responses by addressing fundamental uniformity for data field labels, ensuring confirmation of the receipt of a request and providing for system availability. The rule – which applies to referrals as well as prior authorizations for procedures, laboratory testing, medical services, devices, supplies or medications within the medical benefit – reduces administrative burden and encourages pathways to automation by:

- Requiring use of the 5010X217 278 Request and Response TR3 implementation names for the web portal data field labels for prior authorizations and referrals, which supports the HIPAA-mandated standard transaction.
- Adhering to the requirements outlined in the Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule when the portal operator maps the collected data from the web portal to the 5010X217 278 Request and Response transaction.
- Reducing variation in data element names to ease submission burden and encourage technology solutions to minimize the need for providers to submit information to multiple web portals.

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[16] This rule encompasses all requirements related to data content of the 5010X217 278 Request and Response transactions included in the Phase V CAQH CORE Operating Rules. Whereas in prior phases aspects of data content were broken into separate rules, this rule format addresses industry feedback to combine documents for efficiency.

[17] This rule does not require any HIPAA-covered entity and its agent to conduct, use or process the 5010X217 278 Request and Response transactions if it currently does not do so or is not required by Federal or state regulation to do so. However, it should be noted that under the HIPAA provisions, HIPAA-covered entities who conduct authorizations transactions electronically must use an adopted standard from ASC X12N or NCPDP (for certain pharmacy transactions).

[18] This rule does not require any HIPAA-covered entity and its agent to use a web portal if it currently does not do so or is not required by federal or state regulation to do so.

3. 5010X217 278 Request and Response Data Content Rule: Requirements Scope

3.1. What the Rule Applies To

The X12/5010X217 Health Care Services Review – Request for Review and Response (278) Technical Report Type 3 addresses these types of transactions:

- Admission certification review request and associated response
- Referral review request and associated response – *not applicable to this rule*
- Healthcare services certification review request and associated response
- Extend certification review request and associated response
- Certification appeal review request and associated response
- Reservation of medical services request and associated response
- Cancellations of service reservations request and associated response

3.2. What the Rule Does Not Address

This rule does not address prior authorizations specific to emergency[19] and urgent requests as identified in the following 5010X217 278 Request.

- LOOP ID - 2000E Patient Event Level
    - UM06 1338 Level of Service Code 03 Emergency
    - UM06 1338 Level of Service Code U Urgent

Referral requests as identified in the following 5010X217 278 Request are not addressed in this rule, as industry-wide surveys determined that referral requests are routinely approved.

- LOOP ID - 2000E Patient Event Level
    - UM01 1525 Request Category Code SC Specialty Care Review.

3.3. When the Rule Applies

This rule applies when any HIPAA-covered entity and its agent uses, conducts or processes the 5010X217 278 Request and Response transactions.

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[19] The ACA prohibits requirements for prior authorization to access emergency services under section 29 CFR 2590.715-2719A, patient protections. In line with federal law, a growing number of state laws set additional limits around prior authorizations for emergency and urgent care.

3.4. *Applicable Loops, Data Elements & Code Sources*

This rule covers the following specified Loops, segments and data elements in the v5010X217 278 Request and Response transactions:

Table 1 Applicable Loops and Segments	
Applicable Loops & Segments in 5010X217 278 Request	**Applicable Loops & Segments in 5010X217 278 Response**
Loop ID 2010B Requester Name NM1 Segment	Loop ID 2000A Utilization Management Organization (UMO) Request Validation AAA Segment
Loop ID 2010C Subscriber Name NM1 Segment	Loop ID 2010A Utilization Management Organization (UMO) Request Validation AAA Segment
Loop ID 2010C Subscriber Name DMG Segment	Loop ID 2010B Requester Level NM1 Segment
Loop ID 2010D Dependent Name NM1 Segment	Loop ID 2010B Requester Request Validation AAA Segment
Loop ID 2010D Dependent Name DMG Segment	Loop ID 2010C Subscriber Name NM1 Segment
Loop ID 2000E Patient Event Level HI Segment	Loop ID 2010C Subscriber Request Validation AAA Segment
Loop ID 2010EA Patient Event Provider Name NM1 Segment	Loop ID 2010D Dependent Name NM1 Segment
Loop ID 2000F Service Level SV1 Segment	Loop ID 2010D Dependent Request Validation AAA Segment
Loop ID 2000F Service Level SV2 Segment	Loop ID 2000E Patient Event Level HCR Segment
Loop ID 2000F Service Level SV3 Segment	Loop ID 2000E Patient Event Level HI Segment
Loop ID 2010F Service Provider Name NM1 Segment	Loop ID 2000E Patient Event Request Validation AAA Segment
	Loop ID 2010EA Patient Event Provider Name NM1 Segment
	Loop ID 2010EA Patient Event Provider Request Validation AAA Segment
	Loop ID 2010 EC Patient Event Transport Location Request Validation AAA Segment
	Loop ID 2000F Service Level HCR Segment
	Loop ID 2000F Service Level HI Segment
	Loop ID 2000F Service Request Validation AAA Segment
	Loop ID 2010FA Service Provider Name NM1 Segment
	Loop ID 2010FA Service Provider Request Validation AAA Segment

3.5. *Code Sources Addressed*

This rule addresses the following code sources:

- X12 Standard 901 Reject Reason Code Data Element in each AAA Request Validation Segment of the Loops identified in Table 1 above;
- X12 External Code Source 886 HCSDRC, which communicates the reason for the healthcare services review outcome;[20]
- LOINC Code from the HL7 CDA® R2 Attachment Implementation Guide: Exchange of C-CDA Based Documents, Release 1[21] (Universal Realm) Standard for Trial Use August 2017.

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[20] Health Care Service Review Decision Reason Codes X12 External Code Source 886 communicates the reason for the healthcare services review outcome. http://x12.org/codes/.
[21] HL7 CDA Release 2 Implementation Guide: Additional CDA R2 Templates – Clinical Documents for Payers Set 1, Release 1 – US Realm, Health Level Seven International.

3.6. Normalization, Verification and Matching Submitted Person Identification

This rule applies only to the following characters in a last name:

- Punctuation values as specified in §4.2.1.2;
- Upper case letters;
- Special characters as specified in §3.6.3;
- Name suffixes and prefixes specified as character strings in §4.2.1.1.

3.6.1. When Normalization Applies

This rule applies only when:

- The health plan and its agent are using the X12 Basic Character Set (see §3.6.3 for explanation)
and

- Member Identification is submitted in Loop ID 2010C Subscriber Name

 and

- Last name is submitted in Loop ID 2010C Subscriber Name or in Loop ID 2010D Dependent Name

and

- Last name is used in the search and match logic of the health plan and its agent.

3.6.2. When Normalization Does Not Apply

Normalization does not apply:

- When the health plan and its agent have agreed to use the X12.6 Application Control Structure Extended Character Set;[22]

- When the last name is not used in the search and match logic of the health plan and its agent;

- To military rank designations.

This rule does not:

- Require CORE-certified entities to internally store the data elements specified in §3.4. and other data elements in conformance with this rule, but rather requires that all parties conform to this rule when conducting the HIPAA-mandated 5010X217 278 Request and Response transactions electronically;

- Require conversion of letter case and/or special characters by any party for subsequent processing of the data through internal systems;

- Specify whether a health plan and its agent must validate the full last name or may validate only a portion of the last name;

- Specify the search criteria used by a health plan, or its agent, to identify a patient.

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[22] The X12.6 Application Control Structure-Extended Character Set standard is available at http://store.x12.org/store/.

3.6.3. Approved Basic Character Set[23]

The X12 Basic Character Set consists of:

(1) Upper case letters from A to Z
(2) Digits from 0 to 9
(3) Special characters

    !   "   &   '   (   )   *   +   ,   -   .   /   :   ;   ?
    =

(4) The space character

Note: Special characters are removed from this category when used as delimiters.

3.7. Outside the Scope of This Rule

3.7.1. Extended Character Set

The X12 Extended Character Set as specified in X12.6 Application Control Structure standard is outside the scope of this rule and may be used only by agreement between trading partners. The X12 Extended Character set includes the lowercase letters, other special characters, national characters and select language characters.[24]

3.7.2. Retail Pharmacy Benefits

Retail pharmacy benefit electronic prior authorizations are out of scope for this rule, i.e., pharmacist- and/or prescriber-initiated prior authorization for drugs, biologics and other treatments covered under a pharmacy benefit.[25]

3.8. Maintenance of This Rule

Any substantive updates to the rule (i.e., change to rule requirements) will be made in alignment with federal processes for updating versions of the operating rules, or as determined by industry need or CAQH CORE Participants.

3.9. Assumptions

A goal of this rule is to adhere to the principles of electronic data interchange (EDI) in assuring that transactions sent are accurately received and to facilitate correction of errors for electronically submitted prior authorization requests.

The following assumptions apply to this rule:

- A successful communication connection has been established.

- This rule is a component of the larger set of Phase V CAQH CORE Operating Rules.

- The CAQH CORE Guiding Principles apply to this rule and all other rules.

- This rule is not a comprehensive companion document addressing any content requirements of the 5010X217 278 Request and Response transactions or the 5010X231 999 Implementation Acknowledgement.

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[23] The X12.6 Application Control Structure Section 3.3.1 Basic Character Set standard is available at http://store.x12.org/store/.
[24] X12 Standard is available at http://store.x12.org/store/.
[25] NCPDP is the Standards Setting Organization responsible for standards for retail pharmacy.

- Compliance with all CAQH CORE Operating Rules is a minimum requirement; any entity is free to offer more than what is required in the rule.

4. 5010X217 278 Request and Response Data Content Rule: Technical Requirements

4.1. Requirements for Providers

4.1.1. Patient Identification[26]

When the patient is the subscriber, a provider must submit:

- Patient last name, first name and date-of-birth in Loop ID 2010C Subscriber Name NM1[27] and DMG segments.

When the patient is the dependent, a provider must submit:

- Subscriber last name, first name, date-of-birth in Loop ID 2010C Subscriber Name NM1[28] and DMG segments

  and

- Dependent last name, first name and date-of-birth in Loop ID 2010D Dependent Name NM1 and DMG segments.

4.2. Requirements for Health Plans

4.2.1. Normalizing Last Name

A health plan and its agent must remove the specified character strings and punctuation values in Loop ID 2010C Subscriber Name NM1 segment prior to using last name for subscriber matching or verification:

- When health plan and its agent is using the X12 Basic Character Set

  and

- Member identification and last name is submitted in Loop ID 2010C Subscriber Name

  and

- Last name is used in the search and match logic of the health plan and its agent.

A health plan and its agent must remove the specified character strings and punctuation values in Loop ID 2010D Dependent Name NM1 segment prior to using last name for dependent matching or verification:

- When health plan and its agent is using the X12 Basic Character Set

  and

- Member identification and last name is submitted in Loop ID 2010C Subscriber Name

  and

- Last name is used in the search and match logic of the health plan and its agent

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[26] The health plan and its agent may not require this maximum set of data from the provider and are not required to use all of the data during their search and match member look up; however, when submitted by the provider, the health plan can better identify the patient uniquely when all the data is submitted and used during member look up.
[27] Member ID is not included as it is a required data element in Loop 2010C NM109 Subscriber Segment and CAQH CORE Operating Rules do not repeat implementation specification required data.
[28] Ibid.

To normalize the submitted and stored last name:

- Remove all the character strings specified in §4.2.1.1 when they are preceded by one of the punctuation values specified in §4.2.1.2.

  and

- Followed by a space

  or

- When they are preceded by one of the punctuation values specified in §4.2.1.2.

  and

- Are at the end of the data element

  and

- Remove special characters in the name element.

4.2.1.1.   Character Strings to be Removed During Name Normalization

The following character strings represent the complete set of character strings to be removed when normalizing a last name, as specified in §4.2.1. Any other character strings not included in this section are not covered by this rule.

- JR, SR, I, II, III, IV, V, RN, MD, MR, MS, DR, MRS, PHD, REV, ESQ

4.2.1.2.   Punctuation Values Used as Delimiters in Last Name

The following punctuation values represent the recommended set of punctuation values to be used to delimit (separate) a last name from a name suffix or prefix when a name suffix, prefix or a title cannot be stored separately in internal systems.

  space, comma, forward slash

4.2.2. Consistent and Uniform Use of AAA Error and Action Codes

- When the health plan and its agent detect an error in data submitted in Loop ID 2000A Request the most specific AAA03 901 Reject Reason Code permitted in Loop ID 2000A AAA Segment code set must be returned.

- When the health plan and its agent detect an error in data submitted in Loop ID 2010A Utilization Management Organization (UMO) Name the most specific AAA Error Code AAA03 901 Reject Reason Code permitted in Loop ID 2010A AAA Segment code set must be returned.

- When the health plan and its agent detect an error in data submitted in Loop ID 2010B Requester Request the most specific AAA Error Code AAA03 901 Reject Reason Code permitted in Loop ID 2010B AAA Segment code set must be returned.

- When the health plan and its agent detect an error in data submitted in Loop ID 2010C Subscriber Request the most specific AAA Error Code AAA03 901 Reject Reason Code permitted in Loop ID 2010C AAA Segment code set must be returned.

- When the health plan and its agent detect an error in data submitted in Loop ID 2010D Dependent Request the most specific AAA Error Code AAA03 901 Reject Reason Code permitted in Loop ID 2010D AAA Segment code set must be returned.

- When the health plan and its agent detect an error in data submitted in Loop ID 2000E Patient Event Request the most specific AAA Error Code AAA03 901 Reject Reason Code permitted in Loop ID 2000E AAA Segment code set must be returned.

- When the health plan and its agent detect an error in data submitted in Loop ID 2010EA Patient Event Provider Request the most specific AAA Error Code AAA03 901 Reject Reason Code permitted in Loop ID 2010EA AAA Segment code set must be returned.

- When the health plan and its agent detect an error in data submitted in Loop ID 2010EC Patient Event Transport Location Request the most specific AAA Error Code AAA03 901 Reject Reason Code permitted in Loop ID 2010EC AAA Segment code set must be returned.

- When the health plan and its agent detect an error in data submitted in Loop ID 2000F Service Request the most specific AAA Error Code AAA03 901 Reject Reason Code permitted in Loop ID 2000F AAA Segment code set must be returned.

- When the health plan and its agent detect an error in data submitted in Loop ID 2010FA Service Provider Request the most specific AAA Error Code AAA03 901 Reject Reason Code permitted in Loop ID 2010FA AAA Segment code set must be returned.

4.2.2.1. *Out-of-network Requester, Service Provider or Specialty Entity*

When the requester provider, service provider or specialty entity submitted on the 5010X217 278 Request transaction is determined to be out-of-network, Error Code 35-Out of Network must be returned in AAA03 901 Reject Reason Code Data Element in addition to any other AAA03 901 Reject Reason Code for the following:

- LOOP ID - 2010B AAA – Requester Request
- LOOP ID - 2010EA AAA – Patient Event Provider Request
- LOOP ID - 2010FA AAA – Service Provider Request

4.2.3. *Requesting Additional Documentation for a Pended Response*

4.2.3.1. *Patient Event Level*

When the 5010X217 278 Request transaction includes one or more diagnosis code(s) in Loop 2000E Patient Event Level HI Patient Diagnosis Health Care Information Codes[29] that can be categorized by the health plan and its agent into one or more of the following types of events:

- General Outpatient

- Inpatient

- Surgery

- Oncology

- Cardiology

- Imaging

- Laboratory

- Physical Therapy

- Occupational Therapy

- Speech-Language Pathology

and

Additional medical information is required, the health plan and its agent must return data element HCR01 306 Action Code=A4 Pended and HCR03 Industry Code 0V-Requires Medical Review or HCR03 Industry

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[29] The 5010X217 278 Request Loop 2000E HI Patient Diagnosis segment requires the submission of at least one diagnosis code when known by the provider (requester) and supports the submission of up to 11 additional diagnosis codes.

Code 0P-Requested Information Not Received or HCR03 Industry Code 0U-Additional Patient Information Required in Loop ID 2000E HCR Health Care Services Review Segment to indicate that the review outcome is pended for additional medical information and either:

- The appropriate PWK01 Attachment Report Type Code in Loop ID 2000E PWK – Additional Patient Information Segment.

or

- One or more appropriate Logical Observation Identifier Names and Codes (LOINC) Code from the HL7 CDA® R2 Attachment Implementation Guide: Exchange of C-CDA Based Documents, Release 1 (Universal Realm) Standard for Trial Use August 2017[30] in Loop ID 2000E HI – Patient Diagnosis Health Care Information Codes Segment.

and

- The appropriate PWK01 Attachment Report Type Code in Loop ID 2000E PWK – Additional Patient Information Segment.

When the diagnosis code received in the 5010X217 278 Request transaction cannot be categorized by the health plan and its agent into any of the above types of events the health plan and its agent should attempt to evaluate and respond appropriately to the request. Note: The health plan and its agent are strongly encouraged to evaluate and respond to all received diagnosis codes.

4.2.3.2. Service Level

When the 5010X217 278 Request transaction includes one or more procedure or revenue code(s) in Loop 2000F Service Level SV1, SV2, or SV3 segments[31] that can be placed by the health plan and its agent into one or more of the following types of service:

- General Outpatient
- Inpatient
- Surgery
- Oncology
- Cardiology
- Imaging
- Laboratory
- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology

and

Additional medical information is required, the health plan and its agent must return data element HCR01 306 Action Code=A4 Pended and HCR03 Industry Code 0V-Requires Medical Review or HCR03 Industry Code 0P-Requested Information Not Received or HCR03 Industry Code 0U-Additional Patient Information Required in Loop ID 2000F HCR Health Care Services Review Segment to indicate that the review outcome is pended for additional medical information and either:

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[30] See Appendix – Section 5.3 for further description of Logical Observation Identifier Names and Codes.
[31] The 5010X217 278 Request requires the submission of a procedure or revenue code when known by the provider (requester) in Loop 2000F SV1, SV2, or SV3 Service Level Segments. When the provider needs to submit more than one procedure or revenue code Loop 2000F must be repeated for each additional code.

- The appropriate PWK01 Attachment Report Type Code in Loop ID 2000F PWK – Additional Patient Information Segment.

or

- One or more appropriate Logical Observation Identifier Names and Codes (LOINC) Code from the HL7 CDA® R2 Attachment Implementation Guide: Exchange of C-CDA Based Documents, Release 1 (Universal Realm) Standard for Trial Use August 2017 in Loop ID 2000F HI – Request for Additional Information Health Care Information Codes Segment.

and

- The appropriate PWK01 Attachment Report Type Code in Loop ID 2000F PWK – Additional Patient Information Segment.

When the procedure or revenue code(s) received in the 5010X217 278 Request transaction cannot be placed by the health plan and its agent into any of the above types of service categories, the health plan and its agent should attempt to evaluate and respond appropriately to the request. Note: The health plan and its agent are strongly encouraged to evaluate and respond to all received procedure or revenue codes.

4.2.4. Using Health Care Service Decision Reason Codes (HCSDRC)

- When the health plan and its agent use the HCSDRC in Loop ID 2000E Patient Event Detail HCR Segment, if appropriate, one or more additional HCSDRC should be returned in the HCR Segment, in addition to the required code to provide the most comprehensive information to the submitter.

- When the health plan and its agent use the HCSDRC in Loop ID 2000F Service Level Detail HCR Segment, if appropriate, one or more HCSDRC should be returned in the HCR Segment, in addition to the required code to provide the most comprehensive information back to the provider.

4.3. Detection and Display of 278 Response Data Elements

The receiver of a 5010X217 278 Response (defined in the context of this CAQH CORE rule as the system originating the 5010X217 278 Request) is required to detect and extract all data elements, data element codes and corresponding code definitions to which this rule applies as returned by the health plan and its agent in the 278 Response.

The receiver must display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the 5010X217 278 Response data content.

5. Phase V CAQH CORE Operating Rule Set: Appendix

5.1. Operating Rule Mandates

This CAQH CORE Rule is part of a set of rules that addresses requirements in Section 1104 of the Affordable Care Act (ACA). Section 1104 contains an industry mandate for the use of operating rules to support implementation of the HIPAA standards. Using successful, yet voluntary, national industry efforts as a guide, Section 1104 defines operating rules as "the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications" (ACA, Section 1104). As such, operating rules build upon existing healthcare transaction standards. The ACA outlines three sets of healthcare industry operating rules to be approved by HHS and then implemented by the industry.

The third set of ACA-mandated operating rules address healthcare claims or equivalent encounter information transactions, enrollment and disenrollment in a health plan, health plan premium payments, claims attachments, and referral certification and authorization.[32] The ACA requires HHS to adopt a set of operating rules for these five transactions. In a letter dated 09/12/12 to the Chairperson of NCVHS,[33] the Secretary of HHS designated CAQH CORE as the operating rule authoring entity for the remaining five HIPAA-mandated electronic transactions.

5.2. HIPAA Compliance Requirements

HHS determines whether the system of a covered entity is compliant or noncompliant with the HIPAA Administrative Simplification requirements (which include HIPAA-mandated CAQH CORE Operating Rules). HHS may adjudicate compliance of a covered entity and assess civil money penalties or penalty fees for noncompliance under the following HIPAA Administrative Simplification mandates:

- HIPAA regulations mandate that the Secretary "will impose a civil money penalty upon a covered entity or business associate if the Secretary determines that the covered entity or business associate has violated an administrative simplification provision." (45 CFR 160.402)

- Under the ACA, HIPAA also mandates that HHS is to "conduct periodic audits to ensure that health plans…are in compliance with any standards and operating rules." (Social Security Act, Title XI, Section 1173(h))

5.3. Logical Observation Identifier Names and Codes

Logical Observation Identifier Names and Codes (LOINC), is the international standard for identifying health measurements, observations and documents. LOINC is a freely available global standard used by a diverse global community including reference labs, healthcare organizations, U.S. federal agencies, insurance companies, software vendors and in vitro diagnostic testing companies. More than 78,300 registered users from 175 countries use LOINC to move data between systems. Regenstrief Institute, Inc., a non-profit 501(c)3 research organization serves as the overall steward and standards development organization (SDO) for LOINC.[34]

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[32] The first set of operating rules under ACA Section 1104 applies to eligibility and claim status transactions. These operating rules became effective January 1, 2013. The second set of operating rules applies to electronic funds transfer and electronic remittance advice. These operating rules became effective January 1, 2014.

[33] HHS Letter from the Secretary to the Chairperson of NCVHS. September 12, 2012

[34] For more information about Logical Observation Identifier Names and Codes (LOINC) and Regenstrief Institute, Inc., visit https://loinc.org/.